

Compliance Evaluation

Cherry Hospital

Date of Site Visit: October 29-30, 2007

Date of Report: November 21, 2007

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Code for reading this Evaluation

C = Compliance. Hospital has substantially complied with the requirement.

SC = Significant compliance. Considerable compliance has been achieved on the key components of the requirement, but refinements remain to be completed.

PC = Partial compliance. Hospital has made reasonable gains toward being in compliance with the requirement, but substantial work remains.

NC = Not in compliance. Hospital has made inadequate progress towards being in compliance.

All four measures reflect current outcomes of Hospital's work and are neither a measure of intent nor of effort. In fact, minimal effort in one area might achieve compliance on one item while significant effort in another may still leave the Hospital rated not in compliance on that item.

Font in this Evaluation.

Italics. Items in italics represent those found to be in compliance at the time of prior evaluation.

Bold Face. Items in bold face reflect findings from this evaluation.

DATA BASE

Documents

Forms

Problem List
Person Centered Plan
U2 Group Refused Flow Sheet
U4 Group Refused Flow Sheet
U4 School Refused Flow Sheet
U1 Treatment Mall Refusal Flow Sheet
U3 Group Refused Flow Sheet
Treatment Plan Audit and Compliance Form
Psychology Department Group Audit Form
Recidivism Medical Record Audit
Recidivism Protocol Intervention Audit
Annual Psychiatric Assessment Outline

Assessments

Initial Psychiatric Assessment
0962548 9-5-07
1038665 9-29-07
0985608 9-28-07
1083633 9-7-07
0969443 9-29-07
1038454 9-13-07
1083808 9-13-07
1035322 9-5-07
1076171 9-25-07
1045595 9-22-07
NOS Diagnoses
Audit August, October 2007
Audit December, 2006, February, April, June 2007
Annual Psychiatric Assessment
1013247 8-7-07
0971412 7-25-07
0163279 10-16-07
1022907 10-3-07
0171618 8-24-07

Treatment Plans

Person Centered Plan – Initial
1072374 U12E
0975159 U12W

0930073	U13E
0163041	U13W
0966452	U22E
0167010	U22W
759009	U22W
1066130	U22W
1083633	U23E
0164618	U23W
1083867	U23E
1057792	U4 (Adol)
1084078	Woodard 3W

Person Centered Plan – Review

0147483	U12E
0975159	U12W (Special Review)
0156558	U12W
0910387	U13E
0163279	U13W
0155937	U21E
0968904	U22E
1083296	U22W
1055290	U22W
1035161	U23E
1083606	U23W
1082995	U4 (Adol)
1083431	Woodard 3W
0759654	Woodard 3E
1061007	Woodard 1E
1002904	U43E
1030952	U11E

72-Hour Treatment Plans

LB	10-24-07
1047980	10-29-07
0396295	10-29-07
1084990	10-29-07
102807	10-29-07
1006262	10-25-07
1084916	10-25-07
1084964	10-26-07
1084913	10-25-07
102907	10-29-07

Medication

Psychopharm orders and progress notes for last five admissions with an MR diagnosis

0155937	8-23-07
1041538	9-8-07
0172042	10-11-07
1035801	10-6-07

0167785	9-2-07
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Psychiatric Assessment demonstrating rationale for psychotropic medication(s):

0713212	9-5-07
1083805	9-13-07
0165213	9-27-07
1083975	9-20-07
0168159	9-11-07

List of Active Patients on Antipsychotic Medication, 10-22-07
 Report of Multiple Antipsychotics, 10-22-07
 List of Active Patients on Benzodiazepines, 10-22-07
 Medication Order Justification Audit (Pharmacy Audit), Monthly – 30 charts, August 2006-October 2007
 Justification for Polypharmacy Audits, monthly August 2006-October 2007
 PI project: ADR's, September 2007
 STAT med orders and accompanying progress notes, last two weeks of September 2007

0930740	0153839
0162055	0995423
0045055	0172267
0985608	0171618
1083281	1066130
1007330	0160695
0167010	0164963
1012702	0166191
1083907	1013265
1026813	1057792
0157676	1083314
1084060	1084078
1083867	1083805

PSR

Process for Orientation/Activities Groups and Patients Refusing Groups – U2
 Memo, Jack St. Clair to all staff, re Group Refusals, July 10, 2007
 Memo, Kimberly Johnson, M.D., et al. to all U1 and U3 staff, re Group Refusals, October 17, 2007
 Mall Schedules: U1, U2, Woodard (Gero), Adol
 Schedule for 893 Fitness Club, Monday
 Memo, Jack St. Clair to CH management Team, Serving Patients Across mall Settings, undated
 Activities
 October 2007 Hospital Wide Activities (includes AA weekly on Thursday evening and NA weekly on Monday evening)
 Leisure Activities for Psych Rehab, October 2007
 U2 Evening and Weekend Activities, October 2007
 Geriatric Activities: Long Term, Admission, Psych Med, All, October 2007
 Adolescent Leisure Activities, October 2007
 Riverbend School
 Successes for Riverbend School

DOA and Date of Enrollment, September 2007
Riverbend School Student Schedule
Numbers of patients served on “host malls”, October 29, 2007
Rehabilitation Services Improvements since March 2007
MISA Programming: Improvements since March 2007
Alcoholics Anonymous Attendance, August 9-October 25, 2007
Narcotics Anonymous Attendance, September 24-October 22, 2007

Behavior Interventions

Six most recent Behavior Plans

1066191	October 11, 2007
0038192	October 23, 2007
1063229	October 5, 2007
1057792	September 28, 2007
1083350	September 19, 2007
1002904	October 30, 2007

Case Summary: Terry L.

CH Psychology Department Update, October 2007

Behavior Management Team: List of activities during August-October 2007

Behavior Plan Policy, October 1, 2007

Behavior Modification Training Outline

Behavior Modification Training, Powerpoint/outline

Overview

Basic Principles of Learning

Basic Principles of Behavior Modification

Putting Behavior Modification into Practice

Behavior Modification Training Pretest

Special Populations

Person Centered Plan for Patients with MR Diagnosis

0155937

1033363

1075991

0143774

0452102

Person Centered Plan for Patients with SA Diagnosis

0930073

1083264

0172410

0167732

0973884

List of all patients with dual disorders admitted since July 2007: MI/MR

List of all patients with dual disorders in hospital October 21, 2007

List of all patients with dual disorders: MI/Borderline IQ or MR

SA Assessment Tools

Substance Abuse Assessment

CIWA-Ar
WBJ (ADATC) Acute Care Unit Referral Form for Medical/Psychiatric Detox
WBJ-ADATC Admission Candidate Information

Medical

Death Register, June 1, 2006-October 22, 2007

Admission/Discharge

Response to Specific Questions, October 19, 2007
Diversion Status, January 1-September 24, 2007
Days over capacity, U2, April 1, 2006-September 3, 2007
List of patients with 3 or more admissions in 2007
List of current patients with 10 or more lifetime admissions
Documentation of performance of Recidivism Team, September 2007
Social Work Updates
Walter B. Jones Referral Information
Diversion Process to Walter B. Jones Acute Care Unit (ACU)
Community Resources for Aftercare: A CQI Project
Recidivism
 Performance of Recidivism Team 2007
 Readmit Stats FY 06-07
 Percentage of 30-Day Readmissions to CH, January 2005-September 2007
 Peer Bridger Report, October 11, 2007
CH Census, October 22, 2007; October 29, 2007
Aftercare Plan for Community Follow-up
 1084657 10-24-07
 1036725 10-26-07
 0978995 10-26-07
 1084699 10-25-07
 1040345 10-24-07
 0398215 10-26-07
 0163338 10-24-07
 1038872 10-25-07
 0758321 10-26-07
 1081573 10-25-07
 0388191 10-24-07
 1014783 10-24-07
 1064129 10-25-07
 007038 10-24-07

Policies and Procedures

Staffing, Patterns, and Minimums, September 25, 2007
Alcohol Withdrawal Management, September 1, 2007
Treatment Planning, July 2, 2007; November 1, 2007
Precautions and Standard Accountability, September 1, 2007

Suicide Risk Assessment and Interventions, July 2, 2007
Orders, health Care Practitioners, March 6, 2007
Provision of Treatment for Patients with Substance Abuse/Dependence, September 7, 2007
Progress Notes/Treatment Notes, Frequency and Content, July 1, 2007
Electroconvulsive Therapy (ECT), September 7, 2007
Restrictive Interventions (Therapeutic Hold, Seclusion, Physical Restraint, Chemical Restraint)
Provision of Treatment to Patients with HB-95 Status, November 1, 2007
Forensic Treatment Unit, Referral & Transfer of Patients, July 1, 1999
Provision of Services for Deaf Adult Patients, November 1, 2007 and prior p&p May 7, 2007
Provision of Treatment for Patients with Cognitive Impairment, October 15, 2007
Provision of Treatment for Patients with Mental Retardation, October 23, 2007

QA/PI

Performance Indicator Dashboard, September 2007
Denials and EMTALA
PI projects list
 Person Centered Planning
 Restrictive Intervention Reduction
 Work Therapy
 Behavior Management
PI project flow chart
 Person Centered Planning
Performance Improvement Quarterly Report
 January-March 2007
 April-June 2007
Patient Major Injury Review, January 2005-June 2007
Restrictive Procedures Summary, April-June 2007
Restrictive Procedures Summary, July-September 2007
Environment of Care Quarterly Report, July-September 2007
Total Restraint – 2007
CRIPA Audits, March-October 2007
Incidents and Assaults, September 2007
Restrictive procedures, September 2007
Psychiatric Practice Audit, July-September 2007
Treatment Plan Audit, September 2007
PE Practice Compliance Audit, July 2007

Statistics

List of number of admissions per year, 1990-2007
List of average daily census per year, 1990-2007
List of patient deaths, 1990-2007
Number of patient to patient assaults per year, 2000-2007
Number of patient to staff assaults per year, 2000-2007

Number of patient injuries per year, 2000-2007
Number of restraint episodes and hours per year, 2000-2007, and graph of the same
Number of seclusion episodes and hours per year, 2000-2007 and graph of the same

Staffing

Turnover Rate Analysis by Class Code, January 1-September 30, 2007
Nursing Staff hppd, daily October 14-October 29, 2007
RN shifts provided by agency, August 1-24, 2007
Table of Temporary and Agency employees, October 29, 2007
RN positions; Budgeted, Vacant
Psychiatrists with unit, caseload, FTE
Staff psychiatrists' night and weekend shifts, November 2007
Statement on FTE psychiatrist positions
RN shifts provided by Agency, August 2007

Staff Training and Related

List of all staff training, January 1, 2007-October 18, 2007
Cognitive Impairment: Developmental Disabilities, Traumatic Brain Injury, Dementia
Guardian Consent Workgroup
Family Psychoeducation
Fundamental Group Leadership Skills, May 30, 2007
Group Leader Training, October 5 & 15, 2007
Community Based Resources for SA Population, November 9, 2007 (planned)
Substance Abuse Issues for Treatment Team Members, October 19 and November 5 (planned), 2007
Recidivism Treatment Team Training, September 10; 13, 2007
Assaulted Staff Action Program (ASA) pamphlet
Staff Training in September 2007 included:
 Fire Safety
 Medication Administration
 CPR
 HIPAA
 Chronic Pain
 Increased Precautions
 Person Centered Thinking
 Substance Abuse
 Age Appropriate Care
 Cultural Diversity
 Recidivism Treatment Team
 Code Blue/Medical Emergencies
 Restraint/Seclusion
 Infection Control
 Emtala
 Individual Therapy
 Patients' Rights
 Medication Administration

Treatment Team Planning
Basic Psych Concepts
Medication Reconciliation

Meeting Minutes

Eastern Region Continuity of Care Committee Meeting, February 16, March 16, April 20, June 8, July 20, September 21, 2007
Recidivism Team Meeting, March 9, April 23, June 13, August 10, September 10, October 22, 2007
House Bill 95 Committee Minutes, April 27, May 25, June 29, July 27, August 25, September 28, October 26, 2007

Physical Plant

Chapel: Inspection Corrective Action Plan, 6-26-07
Peer Bridger Building: General Inspection Corrective Action Plan, 8-9-07
Royster: General Inspection Corrective Action Plan, 4-23-07
Special Services: General Inspection Corrective Action Plan, 5-17-07
Building U-1: 2nd Quarter Safety and Sanitation Inspection, 5-15-07
Building U-2: 2nd Quarter Safety and Sanitation Inspection, 5-16-07
Building U-3: 2nd Quarter Safety and Sanitation Inspection, 5-18-07
Building U-4: 2nd Quarter Safety and Sanitation Inspection, 5-22-07
Building Woodward: 2nd Quarter Safety and Sanitation Inspection, 5-23-07
Building Therapeutic Center: 2nd Quarter Safety and Sanitation Inspection, 6-1-07
Building Chapel: 2nd Quarter Safety and Sanitation Inspection, 5-30-07
Building Canteen: 2nd Quarter Safety and Sanitation Inspection, 5-30-07

Outside Reports

JCAHO, September 6, 2007; June 7, 2007
Complaint Investigation #NC 00038458, #NC 00037297, #NC 00036919, #NC 00031776, #NC 00034781
CMS, September 7, September 21, September 24, 2007
Plan of Correction CMS Certification Number (CCN): 34-4003, September 21, 2007
Addendum to Plan of Correction, September 24, September 25, 2007
Follow-up to complaint investigation of September 7, 2007 and Full Validation Survey, October 16, 2007

Onsite Observation

Interviews

Jack St. Clair, Director
Kimberly Johnson, M.D., Clinical Director
Nathaniel Carmichael, Jr., Assistant Director
Steven D. Peters, Psy.D., Director of Psychology
Wendy H. Batderf, Ph.D., Behavior Management Team Supervisor

Bonnie s. Gray, RN, Director of Nursing
 Billy Tart, RN, Assistant Director of Nursing
 Tanya Rollins, Special Services Director
 Richard Courliss, Chief Support Services
 Janet Johnson, Chief Professional Services
 Judy Casey, Compliance Officer
 Rayne Caudill, Active Treatment Coordinator
 Darlene b. Grantham, Unit Director U1 (Acting)
 Sallie Woodard, Unit Director – Adolescent and Geriatric
 Cory Gregory, SW Program Director
 Pamela Johnson, Unit Director/Adult Admissions
 Tesfa-Alan Gebremarked, Acting Associate Clinic Director
 Jane Anthony, Art Therapy-Gero
 Linda Ferrell, RN, Gero
 Shaleta Smith, RN Gero
 Eric Hammond, HCT U2
 Ava Rouse, HCT U2 3E
 Donna Deaver, HCT U2 2W
 Tony Jacobs, U2 3W
 Tim Dean, U2 3E
 Susan Sheffield, U2 2E
 Tim Riley, RN Supervisor U2
 Linda Turner, RN, U1
 Sylvia White, RN, U1
 Dexter Rouse, HCT, U1 (Therapeutic Center)
 Eloise Mitchell, HCT, U1 (U3 1W)
 Edna White, HCT, U1 (U3 2W)
 Robbie Gregory, RT, car wash
 Dawn Carr, RT, Greenhouse

Medical Records

Inpatients

1056970	9-6-57	10-23-07
1066130	11-9-59	8-24-07
0975159	9-16-79	6-14-07
0162055	3-16-59	10-16-07
1082432	6-25-82	8-11-07
1084756	8-5-51	10-18-07
0166756	6-2-65	1-7-05
1008446	10-4-53	11-29-06
0159269	8-3-59	19-14-07
0172042	10-25-80	10-11-07
0155937	7-19-62	10-24-07
0995400	5-28-77	10-12-07
0999285	10-26-80	10-19-07
0166773	3-3-59	11-14-06
0167979	3-1-76	12-23-06

0171618	11-17-75	8-15-06
1043170	3-12-78	9-29-06

Death Records and related documents

169907	1-3-71	2-17-06
		2-17-06
0987810	4-11-74	7-15-06
		7-26-06
1073920	4-8-87	10-22-06
		12-25-06

Treatment Teams Observed

Gero	1061007	TPR
		Psychiatrist, Psychologist, SW, RN, RT, Diet, TPC, HCT
Admissions 3E	1082432	TPR
		Psychiatrist, Psychologist, SW, RN, OTA, Community Liaison LME
Admissions 2W	1056970	Initial PCP
		Psychiatrist, Psychologist, SW, RN, RT, TPC, HCT
		By teleconference: LME liaison, friend of patient
Rehab	1030952	TPR
		Psychiatrist, Psychologist, Intern, SW, RN, RT, TPC, MHT, Pharmacist, Diet
Adol	1002904	TPR
		Psychiatrist, Psychologist, SW, RN, RT, TPC, Pharm, HCT, Teacher, Behavior
		Management Team Rep, Diet
		By phone: LME liaison, Father, Stepmother

Other Meetings

Group Leaders Meeting U2

Groups Visited

Gero (Woodward)

- Sensory Room
- Senior Fitness
- Holding Your Own
- Fitness Club

Admission (U2)

- Fundamental Skills
- Understanding Mental Health
- MISA Community Issues
- Understanding Mental Illness
- Orientation/Activities

Rehab (U1)

- Stress Management (in Therapeutic Center)
- Wellness Management: Recovery
- Wellness Management: Education

MISA community Reintegration
Work Therapy
Community Reintegration

Adol

School Classes: Social Studies, Math, Science, English, Art

Vocational

Car Wash
Green House

Exit Plans: US and NC: Cherry Hospital

Assessments

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Appropriateness of the admission	PC	Recidivism is a major problem. There are 106 patients as of October 22, 2007 with 3 or more CH admissions in 2007 (see Attachment, Table 1). There were 28 inpatients with 10 or more lifetime admissions in CH on October 22, 2007 (see Attachment, Table 2). There were 15 MR patients with 10 or more NC State hospital admissions admitted to CH between July 1 and October 22, 2007 (see Attachment, Table 3).	Recidivism Committee has made a good start, but considerably more focus is needed here. Efforts do merit recognition: The readmission rate in September 2007 was 8.7%; it was 9.7% in August 2007. From January-September 2007, the readmission rate dropped to 8.65% compared to 9.16% for the same period in 2006. Recidivism Team meets monthly to review hospital readmission data, examine potential contributing factors, and explore intervention strategies. The Recidivism Team continues to conduct medical record audits to monitor the implementation of the recidivism protocol by the Teams. Audits focus on readmission cases classified by the UR Department as "Repeaters" (3 readmissions within 30 days of discharge). Treatment Team members were trained during September on how to address recidivism issues in the treatment plan. Training presented by Dr. Kimberly Johnson. Social Work Department has developed a protocol for teleconferencing with the LMEs to enhance collaboration on recidivism cases. Peer Bridger program has demonstrated success in reducing readmissions for patients served. Program data reports typical patients served by the program averaged 5.08 hospitalizations in a year prior to receiving services compared to .23 hospitalizations.
Other less restrictive settings (VIIB)	C	<p>LRA</p> <p>House bill 95 Committee has made excellent progress since its inception April 2007. To date, the Committee has orchestrated: a) the discharge of 4 patients to community placements, b) the return of one patient to jail as competent to proceed, and c) the dismissal of charges for two patients. Dismissal of charges is actively being considered by the DA for five additional patients at the instigation of the Committee.</p> <p>Walter B. Jones ADATC, which has been a major player in CH's diversion, admission, and discharge of persons with primarily SA problems or dually diagnosed MISA patients is about to decrease its rehab beds by 50% for renovations. This decreased capacity will exist an estimated 8 months.</p>	CH needs to work with Walter B. Jones to develop alternatives to just being without their usual number of beds for 8 months.
Multidisciplinary with attention to co-morbid diagnoses, i.e., MRMI and	C	<p>MR</p> <p>On October 22, 2007, there were 19 patients with</p>	

MISA (IIIA1,B1,B5)		<p>MR (14 mild, 5 moderate) and 3 patients with Borderline IQ. The total number of patients admitted with MR diagnoses July 1-October 22, 2007 was 94 individuals.</p> <p>Section 3C on the Person Centered Plan specifically addresses potential impediments to patient's ability/readmission to learn: (1) Ability to understand written instructions, (2) Ability to understand verbal instructions, (3) Patient's receptivity to learning, (4) Family receptivity to learning. Section 3C was appropriately completed for persons with an MR diagnosis for 1055937, 1033363, 1075991, 0143774.</p> <p>Section 3B asks if there are factors that prevent the patient from participating in treatment. Some of these factors are "Cognitive Barriers", "Communication Barriers", and "Physical Limitations." Section 3B was appropriately filled out for 1055937, 1033363, 1075991, 0143774.</p> <p>Patients with MR need more action/attention to vocational goals. See absence of this in 1033363 (Patient "is not motivated to work; feels he's not able"); 0452102 (no plan to advance current vocational functioning.)</p> <p>Patients with diagnosed MR, but who are illiterate also have this recognized in Sections 3: 1083264.</p> <p>SA SA is identified as a diagnosis, a problem, and actively addressed on the PCP: 0930073; 1083264, 0172410, 0973584.</p> <p>There are a reasonable number of interventions on the PCP to address SA: 0930073, 1083264, 0172410.</p>	
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		<p>Inadequate attention to the vocational needs of persons dually diagnosed with MI/SA: 0930073, 0172410, 0167732, 0973584.</p> <p>SA withdrawal addressed in PCP as needed: 1083264.</p> <p>In some PCPs there are inadequate interventions for a SA problem: 0167732, 0973584.</p>	
Psychological identifying Suicide risk (IIB2)	C	<i>Suicide and Violence Risk Assessment completed on all admissions (p. 4 of Evaluation for Admission). Suicide assessment on RN Assessment.</i>	Good form.
Self-injurious behavior risks (IIB2)	C	<i>Suicide and Violence Risk Assessment completed on all admissions (p. 4 of Evaluation for Admission). Specific indicator for previous acts of self-harm.</i>	
Cognitive strengths and weaknesses (IIB2)	C	<i>Mental Status Exam on Evaluation for Admission, Initial Psychiatric Assessment. Strengths section on Evaluation for Admission.</i>	
Identify and prioritize patient needs with particular attention to “special needs” Suicide risk (IIB4)	C	<i>Level of observation determined and assigned at admission (p. 8 of Evaluation for Admission).</i>	The need for CH to attend to persons with MR diagnoses is apparent from the data on the population CH admits. Significant gains have been made. Specific programming that is less language-based needs to be developed.
Self-injurious behaviors	C	<i>Level of observation determined and assigned at admission (p. 5 of Evaluation for Admission).</i>	
MI/MR	SC	CH has admitted 94 individuals with an MR diagnosis July 1-October 22, 2007. At least 13 of these individuals were admitted more than once in this time period. The number of CH admissions ranged from 1 to 36. Seventeen (17) of these	

MI/SA (IIIB2)	C	<p>individuals have 10 or more lifetime CH admissions. There were 48 discharges in 2007 that <i>preceded</i> the last admission.</p> <p>MISA PROGRAMMING: Improvements since March 2007</p> <p>1) Implementation of new SA Assessment tool by Psychology, 2) Developed MISA treatment tracks, 3) Implemented weekly AA meetings 8-8-07, 4) Implemented weekly NA meetings 9-24-07, 5) Added SA education to health curriculum at Riverbend School, 6) Added position of Social Work MISA Program Specialist, and 7) Implemented “Fast Track” protocol to facilitate referral/admission to ADATC (Had 34 of 39 referred patients accepted during August/September).</p>	
Hearing impaired (IIIB6)	N/A	No cases.	
Psychopharmacological examination of appropriateness of current and ongoing pharmacological treatment for behaviors (IIID6)	PC	<p>Admitting and Initial Psychiatric Assessments continue to fail to justify meds prescribed on admission.</p> <p>Five (5) recent Annual Psychiatric Assessments were reviewed – see Data Base. The Annual Psychiatric Assessments are significantly improved from the time of the preceding Compliance visit (2-07).</p>	
Medical (VB)	C	<p><i>Review of systems, Medical Nutrition Therapy, Pain Management, Physical Therapy, and Physical Exam (with AIMS) done by Physician Extender. ROS, pain assessment on RN Assessment. Falls Assessment by RN. Dental Assessment.</i></p> <p><i>Examples of Admission History and Physical, AIMS and labs or Annual evaluations of the same that meet requirements include: #016448,</i></p>	

		#0165213, #0156749, #1010026, #1075052, #1031769, #0143774, #1023352, #0160273, #0998525. <i>Obesity consistency evaluated and included on Axis III.</i>	
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Treatment Plans

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Individualized (IIIA5) Initial Psychiatric Assessment	PC	<p>Initial Psychiatric Assessments often do not provide adequate Initial Treatment Plans. The ITP must be well conceived since the Team has up to 10 days to do the CTP. See for example 1038655: Data: 1) Rapid readmission: admitted to CH on 9-16-07, discharged on 9-25-07, readmitted for this admission 9-29-07. 2) Long history of psychotic disorder. 3) On admission, increasingly delusional, uncooperative, refusing to answer any questions. 4) Long history of non-compliance with medications. Patient needed to be started on forced medications during her last admission. 5) Extensive history of alcohol abuse, also with prior history of cannabis abuse.</p> <p>Initial Treatment Plan 1) will continue to monitor patient's mood and behavior; 2) collateral information; 3) complete physical and lab work-up; 4) ward and milieu therapy; 5) continue patient on haldol to adjust psychosis, continue patient on lithium to stabilize mood. Adjust medications as needed; 6) complete treatment planning</p> <p>The Initial Treatment Plan can be fairly close to generic (1083633). 1) Patient was admitted to acute level of care to assess his condition and for further evaluation and observation. 2) Routine labs and orders. 3) Psychotropic meds. Will start</p>	Is the ITP section of the IPA only to cover the psychiatrist's own interventions, or is it supposed to cover the patient's treatment, all aspects of which are overseen by the psychiatrist? From my perspective it needs to be the latter, especially with PCP's at 10 days and the 72-hour plans boilerplate.

72-hour	PC	<p>him on risperdal for psychosis and ativan for anxiety and cogentin for EPS. 4) Milieu therapy. 5) Collateral information.</p> <p>Even on well done IPA's, the ITP section is generally restricted to medications and discharge, see 0985608.</p> <p>Another example (1038454), age 17-years-old. Initial Treatment Plan: Admit to CH for further evaluation. Monitor for mood, behavioral symptoms, and dangerousness. Routine screening, physical exam, lab work, and review labs when available. Routine assessments by social work, psychologist, school liaison, assign to Riverbend School, evaluate and assign to appropriate PTP groups based on individual needs. Ward and milieu therapy and level system. Medications: Patient is resistant to being on medications, will monitor patient on the unit. Consider a trial of an atypical antipsychotic to target his mood liability and aggression.</p> <p>Compare the similarity with a second 17-year-old (1083808). Initial Treatment Plan: The patient will be admitted to CH for further evaluation and monitored for mood, behavior symptoms, and dangerousness. He will receive routine screening, physical examination, and lab work. The labs will be reviewed when available. He will receive assessments by social work, psychology, and the school liaison as well as being assigned to Riverbend School. He will be evaluated and assigned to appropriate PTP Groups based upon his needs with involvement in ward and milieu therapy and the Level System. Medications: The patient's mother states that she does not wish him to be on medications.</p> <p>Ten (10) of the most recent 72-hour plans were</p>	
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PCP (10-day)	C	reviewed – see Data Base. These plans are supposed to direct treatment from no later than end of third day of hospitalization through tenth day. These plans cannot do that. They fail to be patient-centered, individualized, integrated or coherent. For the same label, e.g., “Substance Abuse Disorders”, the group interventions cannot only be exactly the same, but listed in exactly the same order – compare 1047980 and 0396295.	Excellent progress.
Interdisciplinary (IIIA5a)	C	Based on observation of Treatment Teams and review of PCP’s (see Data Base).	Congratulations!
Based on Assessment data (IIIA5a)	PC	<p>PSR Goals 1066130 STG’s on PCP are not the same as on Individual’s Schedule. Having “Patient will attend PSR groups daily” does not make sense as the STG for <i>every</i> group or even for <i>any</i> group unless attendance is a problem and is being addressed as such.</p> <p>0975159 Every group has the same one STG. How is the patient’s MR being taken into account in the groups she is in?</p> <p>1082432 Every group has the same one STG. STG has much too long a timeframe for the acute unit groups, i.e., 4 weeks.</p> <p>0166756 Every group has the same one attendance STG. This seems problematic, i.e., an attendance goal, for patient in CH 2.75 years.</p> <p>1008446 Every group has the same one STG. For some groups, this STG makes no sense</p> <p>0159269 Most groups have the same one ill-defined</p>	

		<p>STG: "Pt will display appropriate social behavior meetings (sic). 0999285 Every group with same one STG for patient with dual disorder MI/MR who never got out of Fundamental Skills.</p>	
Attend to co-morbid diagnoses (IIIA1, B5)	SC	See above.	
Involve patient in identifying goals and objectives (IIIA3)	PC	Based on observations of Treatment Teams and review of PCP's (see Data Base), Treatment Teams continue to most often impose <i>their</i> goals on the patient.	This should be a focus of training: Goals and Objectives belong to the patient.
Involve family/guardian when appropriate (IIIA3)	SC	<p>Family Involvement Family Psycho-education support groups started in Adolescent and Geriatric Units. Adult Admissions Unit group ongoing. Working on development of best practices family group for Psych-Rehab Unit.</p> <p>Continue efforts to enhance family involvement in treatment process/treatment team meetings.</p> <p>Utilization of conference calls, teleconferencing to involve families in meetings.</p> <p>Family Day scheduled 11-30-07.</p>	
Reviewed and revised as clinically indicated (IIIA5b)	PC	<p>Reason for Continued Stay are not specific and fail to justify further CH treatment</p> <p>0155937: "Mr. B. needs further stabilization and to develop social skills for community re-entry."</p> <p>0930073: Mr. P. "is actively delusional, but denies his mental illness."</p> <p>1083264: Mr. M. "presented to CH on affidavit and petition for involuntary commitment stating, 'Respondent is mentally ill and dangerous to self and others.'"</p>	

Treatment Plan Content includes Suicide precautions (if appropriate) (IIB2)	C		Huge improvement.
Measurable behavioral goals and objectives, i.e., basis for quantifying progress (IIIA5a)	SC		
Emphasis on teaching alternative adaptive behaviors (IIIA6)	PC	See below.	
Identified least restrictive interventions (IVC)	PC	See sections on basis for continued hospital stay, discharge.	
Explanation of psychopharmacological interventions with particular attention to the prescription of Benzodiazepines (IIID6)	C	<i>Generally found with reasonable specificity for antipsychotics, less so for benzodiazepines, but still within reasonable degree of compliance. Superior to many state hospitals.</i>	<i>CH doing a better job than most state hospitals. Psychiatrists should continue to work to make these as specific to the patient and the use of each medication as possible.</i>
Antipsychotic medications (IIID6)			
Criteria for use of seclusion and/or restraint as last resort (IVC)	N/A		Does not belong in PCP.
Criteria for release from seclusion and/or restraint (IVF)	N/A		Does not belong in PCP.
Education about diagnoses	SC	Generally the PCP has intervention for education, but the time allotments for this are often too brief	

(IIC2)		to effectively accomplish this. This intervention is not being individualized based on the patient’s actual current knowledge about his/her diagnosis.	
Skill building for Problem-solving techniques (IIC1)	PC	Rehabilitation Services Improvements since March 2007	CH has done a terrific job of instituting off ward programs, i.e., Treatment Malls. The PCP and the groups at this point provide patients the opportunities to <i>practice</i> skills, but no one is teaching the skills. Groups need to evolve from all groups for a single STG to specific groups to teach specific skills directed at meeting specific STG’s.
Self-medication skills (IIC3)	PC	1) Work Therapy has expanded from serving 54 patients in April 2007 to a current patient census of 71 (October 2007). 2) Obtained a second greenhouse for Work Therapy program. Rehab Services received a grant from the Cherry Foundation to purchase this addition which will allow for more work assignment opportunities and additional projects for the greenhouse program. 3)	
Symptom management (IIC4)	PC	Assumed responsibility for the hospital canteen effective August 1 to provide more opportunities for patients in work therapy program. Currently patients are assigned to work in the “interim” canteen until renovation of the permanent canteen facility is complete. 4) Obtained three new positions in Work Therapy. Two brand new positions include the Community Employment Services Representative and a Community Production Specialist. Plan to have more work from the community and be able to assist patients in being gainfully employed after discharge. An additional Rehabilitation Therapist was hired who will assist with operating the canteen. Two new Therapeutic Recreation Specialist positions allow for more active treatment groups and active treatment programming. 5) Expanded services at the Carwash by contracting with Eastpointe LMF to wash/wax their agency vehicles. Currently exploring a contract opportunity with O’Berry. 6) Workshop has taken on a new project of collating and stapling the hospital handbook to be distributed to patients and their families at admission. 7) Added a structured exercise program in the adolescent unit to increase	
Cognitive and psycho-social skills (IIC5)	PC		
Moderation or cessation of substance use (if appropriate) (IIC6)	SC		

		<p>to be done?</p> <p>0155937 4 admissions in 2007; 8 days between previous discharge and current admission; MR diagnosis; “repeat hospitalization” mentioned, but not adequately addressed as per 0172042</p> <p>0995400 3 admissions in 2007; 10 total admissions; 23 days between previous discharge and current admission; no mention of repeat utilization of CH in any treatment planning document/problem list</p> <p>0999285 4 admissions in 2007; 10 total admissions; 8 days between previous discharge and current admissions; record silent on repeat hospitalizations for yet another patient with Axis II diagnosis of MR</p> <p>0166773 22 total admissions; inpatient currently almost one year; frequent admissions mentioned, but no adequate plan to assess etiology and develop plan</p> <p>1002904 15-year-old at CH for 5th CH admission, states he wants to stay at CH; he stops taking insulin, destroys all his insulin equipment and says he’ll die to cause readmissions to occur</p> <p>As an example, 1035161. Continuity of Care Planning: 1) Mr. B needs placement in the community. He would prefer to live on his own, but due to his psychosis needs supervision to stay treatment compliant. 2) Mr. B would benefit from individual therapy focusing on understanding his mental illness. 3) Eastpointe MHC will coordinate his aftercare. 4) He would benefit from ACT team services to help him stay treatment compliant. 5) Mr. B receives disability and Medicare to pay for his placement. 6) Will need to follow-up with his doctor regarding his head trauma and shunt. 7) Would benefit from a sheltered workshop program</p>	
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		to help him stay busy during the day. 8) Mr. B has completed high school and some college, but does not wish to pursue any further education.	
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Policies

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Ensure patients with “special needs” are appropriately evaluated, treated and monitored	C	CH has a Clinical Care Plan (policy and procedure) that addresses Provision of Treatment for Patients with Cognitive Impairment, effective 10-15-07. This policy indicates 1) Admitting Psychiatrist assesses the severity of the patient’s cognitive impairment and makes a clinical determination, based upon the patient’s age, his/her degree of estimated cognitive impairment, and his/her individualized needs, which admissions unit and ward is most appropriate; 2) Patients with cognitive impairment are placed on precautions when their cognitive impairment and/or psychiatric symptoms suggest precautions are necessary to help ensure their safety from self or others; 3) Patients with evidence of moderate and severe cognitive impairment receive a) cognitive testing (such as, but not limited to, an IQ test) by a Psychologist within 24 hours of admission, b) adaptive behavior assessment by a Psychologist within 24 hours of admission, c) functional assessment by an Occupational Therapist if recommended; the functional assessment is completed within 96 hours from the time of referral; 4) Patients with evidence of mild cognitive impairment receive a) cognitive testing (such as, but not limited to, an IQ test) by a Psychologist prior to the comprehensive treatment plan (if applicable), b) adaptive behavior assessment by a Psychologist prior to the comprehensive treatment plan (if applicable), c) functional assessment by an Occupational Therapist prior to the comprehensive treatment	

Suicide risk (IIB4)	C	<p>plan (if applicable); 5) Consulting medical Staff are available for second opinions regarding the management of patients with cognitive impairment by a referral form completed and sent to the Clinical Director's office.</p> <p>CH has a Clinical Care Plan (policy and procedure) for Provision of Services for Deaf Adult Patients, effective 11-1-07. P&P indicates that when a deaf patient is admitted to CH, the Admission Office notifies the Wilson-Greene Deaf Services Unit and RNO; the assigned social worker provides information from the psychosocial assessment to the Wilson-Greene Deaf Service Unit; the psychiatrist orders an interpreter; the Treatment Team considers recommendations from the Regional Adult Coordinator of Mental Health Services for the Deaf in formulating a treatment plan and/or facilitating transfer to the Broughton Hospital Deaf Service. CH has also contracted with two additional Sign Language Interpreter Services.</p> <p><i>Suicide Risk Assessment (VI-S-2b)</i> <i>Suspected Risk, Suicide (VI-S-2)</i> <i>Precautions, Special (VI-S-2a)</i></p> <p>CH has a Clinical Care Plan (policy and procedure) on Precautions and Standard Accountability, revised as of 9-1-07. This P&P defines assigned staff, building restrictions, close observation (CO), constant awareness (CA), escape precautions, meals on ward, responsible physician, precautions, Q15-minute checks, standard patient accountability, supervision ratio, and ward restrictions. The P&P explicates among other things: 1) Standard Accountability Requirements and Documentation, 2) Initiation of Precautions, 3) Orders for Precautions, 4)</p>	<p><i>Includes requirement Attending assess and document suicide risk at discharge.</i></p>
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Hearing impaired (IIIB6)	C	See Physical Plant Sec	
Reduce the use of forced intramuscular medication that differs from the patient's prescribed oral medication (IIID4b)	C	Prescribing of Psychotropic Medication (VI-P-12) Forced Medications (VI-A-3) Antipsychotic Polypharmacy (VI-P-13)	From policy: "combination therapy using psychotropic agents from the <u>same</u> pharmacological class is seldomly consistent with current psychiatric practice." CH is not adhering to its own policy (see Practices from policy: "Monotherapy is the goal").
Use of restraints or seclusion (IVA,D)	C	Restrictive Interventions (VI-R-3)	See above. Policy calls for persons in seclusion to be on CO. This is an error since cannot be arm's length.
Use of PRN psychotropic medications (IVB)	C	Orders, Health Care Practitioners (VI-O-3). This policy prohibits use of PRN psychotropic medication.	From policy: "All PRN orders shall require justification." Also, "All orders shall have justification documented on the Physicians Order Sheet"; hence, PRN, STAT, Verbal and Telephone Orders need justification. Prohibition on PRN psychotropic medication is excellent.
Individual with health problems are identified, assessed, diagnosed, treated and monitored	C	Orders, Health Care Practitioners (VI-O-3) Medical Assessment and Ward (VI-M-11)	

Procedures

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Health problems (identified, assessed, diagnosed, treated and monitored) (VB)	C	Identified at time of admission: Admission H&P, RN Assessment, Psychiatric Admission. Included in Treatment Plans: H&P, AIMS, Labs consistently completed and timely (see Assessment Section). Difficult cases well managed, e.g., #1067021. Follow-up medical care and referrals to general medical hospital ER (Jan 20-Feb 20, 2007)	
Investigating untoward events, serious injuries, and sentinel events	C	P/P: Incident/Accident Reports, VI-I-1 Sentinel Event/Near Miss, VI-S-5	

(V1A2)		<p><i>CH Quarterly Report</i></p> <p>Assault There were no assaults July to October 29 that resulted in major injury to patients. There was one assault that resulted in one major injury to staff. This occurred on U12W (admission unit).</p>	
<p>Routinely reviewing incident reports to assess individual or systemic trends or issues exist and changes in treatment are warranted (V1A3)</p> <p>Investigating untoward events, serious injuries, and sentinel events (VIA2)</p>	C	<p><i>See Quality Assurance and Performance Improvement Section</i></p> <p><i>Two incidents reviewed in their entirety:</i> <i>#1010026, 12/27/06</i> <i>#1065304, 1/13/07</i></p> <p><i>All incidents for December 2006 reviewed. Eight incidents referred for additional information.</i></p> <p><i>See Quality Assurance and Performance Improvement Section.</i></p>	<p><i>Timely review and resolution of incidents warranting investigation completed.</i></p>
<p>Routinely reviewing incident reports to assess whether individual or systemic trends or issues exist and changes in treatment are warranted (VIA3)</p>	C	<p><i>As above.</i></p>	

Practices

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Case formulation (IIID6)	C	<p><i>Well done as part of TP.</i></p> <p>Formulation has a designated section on the PCP – good. This section has designations to be completed of: Predisposing, Precipitating, Perpetuating and Protective factors – good. These</p>	<p><i>While Case Formulations are not at threshold (per CH's audits), far better than many state hospitals.</i></p> <p>Add a subsection to Section 8 of the PCP that integrates the four factors to describe how they interact to create problems requiring treatment.</p>

		four sections are routinely completed – good. What is lacking is an integrating section that puts these factors together into a picture of the person.	
Monitored, documented, and reviewed by qualified staff (IID1) Use of anti-psychotics	PC	See Table 4 (attachment). The problem with counting the brief statements made on order sheets as adequate justification for meds is that there is no integration of different meds given at different times. In the examples that follow in the tables, + is for the reasonable justification, - is for a marginal justification and 0 is for no comment at all. 1066130. Note in this patient, STAT meds on one day included multiple doses of lorazepam for patient on standing order for Clonazepam and two different antipsychotic medications: (see Table 5 – attachment). 0975159. In this patient, there is no explanation as to why 2 medications were needed STAT on 10-22 nor why CPZ was started on 10-8 when no antipsychotic used previously: 10-5 Lorazepam now - N CPZ now - N 10-8 CPZ HS - N 0162055. There is no reconciliation of now meds with standing orders. Standing orders: Quetiapine 450mg Haloperidol 20mg Lorazepam 4mg Zolpidem 5mg Now orders: 10-19: Zolpidem 5mg 9:00 a.m. 10-22: Haloperidol 5mg + Lorazepam 2mg Well done progress note of 10-18-07 addresses polypharmacy	CH should consider eliminating the justification column on the order sheet and should require progress notes as the venue for all justifications.
Medication combinations	PC		

		<p>1084756. Justification for medication is simply the generic reason (the class):</p> <p>Risperidone psychosis Lorazepam anxiety Trazodone sleep Clonazepam agitation</p> <p>No discussion of med-med interactions. No discussion of patient being on 2 benzodiazepines for 6 days – appears this was an error as psychiatrist never discontinued Clonazepam when he started lorazepam; this was only picked up on Discharge/Visit Order Sheet.</p> <p>There is not one progress note that addresses medication DOA (10-18-07) through DOD (10-25-07)</p> <p>0166756. Patient is on cross titration risperidone to clozapine and on quetiapine and on olanzapine. Hence, four antipsychotic medications. There are frequent explanatory progress notes written by Dr. McKnight.</p> <p>1008446. Polypharmacy: risperidone, aripiprazole. Progress notes by Dr. McKnight provide rationale.</p> <p>0159269. Now order on 10-20: risperidone and lorazepam. Progress note by 10-22 discusses and is good note. Ordering physician does not explain why 2 medications were required or why 8mg risperidone in 24 hours (standing + STAT order) was advisable.</p> <p>0155937. Patient transferred to Wayne Memorial Hospital 10-22. Returned 10-24.</p>	
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		<p>Medication orders have no rationales on the order sheets. There is no progress note that discusses medication. Patient is on quetiapine, clozapine (misordered as Clonazepam and corrected later the same day), lithium, lorazepam.</p> <p>0995400. Patient admitted on 10-12 on olanzapine and haloperidol. Justification on order sheet says: “psychosis.” Patient discharge on 10-22 on same two medications at same dosages. The Initial Psychiatric Assessment does not justify polypharmacy. There are two brief psychiatric progress notes; neither mentions medications at all.</p> <p>0999285. Patient admitted 10-19 and discharged 10-26-07. Diagnosis: I. Schizoaffective, II. Mild MR. The only rationale anywhere in the record for medications are 1-2 words per medications which follow:</p> <p style="padding-left: 40px;">Aripiprazole psychosis Clonazepam mood stabilization Topiramate mood stabilization</p> <p>This is not adequate justification for each medication. This is simply stating an indication for an antipsychotic and an off-label use for each of two medications.</p> <p>0166773. Patient is on quetiapine, risperidone, haloperidol, lithium. Hence, standing orders for 3 antipsychotic medications in October 2007. Well written, frequent progress notes by Dr. McKnight.</p> <p>0167979. Patient, who has been CH inpatient 10 months is taking quetiapine, risperidone, haloperidol, lithium, divalproex, trazodone. Hence, 3 antipsychotic medications, 2 mood</p>	
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		<p>stabilizers. Last antipsychotic medication change was 8-21-07 when risperidone dose increased; only rationale is on order sheet: “psychotic agitation.” There is an 8-21 progress note, but it does not explain medications. There are progress notes that mention polypharmacy, but no explanation for why patient is not on maximal dose of any <i>one</i> of the antipsychotics to see effectiveness of this. Justification not adequate.</p> <p>0171618 (see Table 6 – attached). No explanation for use of 4 antipsychotic 10-5 to 10-14. There is rationale for cross taper Olanzapine to CPZ on 10-15, but that is based on information not available earlier. Olanzapine was discontinued 10-18. Still on 3 antipsychotics without adequate justification.</p> <p>1043170. Patient at CH for 13 months. Currently on olanzapine, quetiapine, risperidone, diazepam (dose was 25mg/day on 10-2 before taper began), divalproex. There are recent progress notes (Sept-Oct) that mention polypharmacy, but none explain multiple medications in face of less than maximal doses of each. No explanation of why patient on high dose diazepam over 1 year into hospitalization in patient with polysubstance dependency diagnosis.</p> <p>CH CRIPA audits are showing compliance with prescribed medication justified on the Order Sheet at rates ranging from 81% (March) to 95% (October); these rates are considerably higher than I found. The difference is what is considered justified based on a qualitative review. However, just writing anything (quantitative review) has certainly improved.</p>	
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		<p>CH CRIPA audits are showing compliance with benzodiazepines justified on the Order Sheet at rates ranging from 43% (March) to 89% (October); these rates are considerably higher than I found. The difference is what is considered justified based on a qualitative review. However, just writing anything (quantitative review) has certainly improved.</p> <p>Polypharmacy</p> <p>On October 22, 2007, there were 207 CH patients taking antipsychotic medication. Of these, 47 (23%) were on 2 or more antipsychotic medication. Those who joined the ranks of two or more because one medication was a PRN numbered one patient. Hence, 46 patients had at least two standing orders for antipsychotic medications.</p>	
Pro re nata (PRN) and STAT orders (IID2)	NC	<p>CH CRIPA audits show CH still struggling to document STAT/NOW orders. Justification on the Order Sheet ranged from 14% (March) to 35% (August) on monthly audits March-October 2007. These results represent quantitative results (any wards); qualitative results are even lower.</p> <p>See Table 7 (attached).</p>	CH needs to direct its attention to justifying the ordering of STAT/NOW medications. A note should be written by the ordering physician for each order, and if not, should be written by the Attending Psychiatrist the same or next business day. Nurses are doing a reasonable job of documenting administration and effect.
Intramuscular injections (IID5)	C	<p><i>Long-acting injectable antipsychotic medication is prescribed as follows:</i></p> <ul style="list-style-type: none"> - haloperidol decanoate 20 patients - risperidone consta 8 patients - fluphenazine decanoate 5 patients <p><i>IM back-up for oral refusal of medication was found for 14 patients. Given NC statutes, this does not evidence the excess of use of IM medication.</i></p>	<i>Use of depot medication appears to be clinically appropriate. No evidence of underutilization which one often sees. No evidence of abuse of IM medication over objection.</i>

Benzodiazepines (IHD2)	PC	<p>Use of IM Long Acting Medication</p> <table border="1"> <tr> <th></th><th>Only Med</th><th>Also in others</th><th>Total</th></tr> <tr> <td>Haloperidol Decanoate</td><td>3</td><td>15</td><td>18</td></tr> <tr> <td>Fluphenazine Decanoate</td><td>1</td><td>3</td><td>4</td></tr> <tr> <td>Long Acting IM Risperidone</td><td>1</td><td>6*</td><td>7</td></tr> <tr> <td>Total</td><td>5</td><td>24</td><td>29</td></tr> </table> <p>* 5 of 6 have oral risperidone as only other antipsychotic medication</p> <p>Benzodiazepines: On October 22, 2007, 78 patients were on benzodiazepines. Leaving aside patients on benzodiazepines for alcohol detoxification (n=4), there were 74 patients on benzodiazepines for psychiatric purposes. Individualized reasons for using benzodiazepines were generally lacking. Rationales were usually generic phrases like: “anxiety”, “agitation”, “mood swing”, “irritability”, or “psychotic agitation.” Tracking the specific effectiveness of the benzodiazepine is most often not apparent.</p> <p>Of those patients taking more than two antipsychotic medications, there were four patients taking three antipsychotics and two patients taking four. Of this group (n=6), one patient (on three antipsychotics) was included by dint of having a third antipsychotic as a PRN.</p> <p>Also, see above.</p>		Only Med	Also in others	Total	Haloperidol Decanoate	3	15	18	Fluphenazine Decanoate	1	3	4	Long Acting IM Risperidone	1	6*	7	Total	5	24	29	
	Only Med	Also in others	Total																				
Haloperidol Decanoate	3	15	18																				
Fluphenazine Decanoate	1	3	4																				
Long Acting IM Risperidone	1	6*	7																				
Total	5	24	29																				

Protocols*

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Nursing protocols for medical care and treatment (VC)	C	<p><i>See NSPM 1-16</i></p> <p><i>No documents labeled “protocols” exist.</i></p> <p><i>Practice, as demonstrated in records and patients’ physical condition, shows performance adequate.</i></p>	
Nursing protocols to ensure that patients are appropriately supervised and monitored (VIB2)	C	<i>See NSPM 17-21</i>	

* For NSPM codes, see Document List.

Plans

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Appropriate evacuation plans (VIB3)	C	<i>Site Specific Evacuation Plans, Fire Evacuation Maps reviewed and meet requirements.</i>	

Physical Plant

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments Recommendations</u>
Modifications for hearing impaired (IIIB6)	C	<p><u><i>Building Modifications:</i></u> All patient care areas of the hospital are equipped with fire alarms which have both an audible tone and a flashing strobe light. Alarms are located in all corridors and in some bathrooms. CH policy requires all patients to be evacuated from the immediate area in the event of fire. Unit staff is responsible to conduct a head count to insure all patients are accounted for.</p> <p><u><i>TTY Equipment:</i></u> The hospital has two TTY devices, both stored in the Royster Nursing Office. When a hearing impaired patient is admitted, the</p>	

		<p>unit staff contacts Royster Nursing Office. A TTY is delivered for the patient's use. All patient care units are TTY capable.</p> <p><u>Interpreter Services:</u> The hospital contracts with two interpreter services for the hearing impaired: Fluent Language Solutions, Inc. and Deaf Access, Inc. Scheduling arrangements for interpreters made through the Professional Services Office. Interpreters are available to facilitate patient care and assessments as well as their participation in treatment team and treatment mall activities 24/7. During 2006, interpreter services were acquired for nine patients.</p> <p><u>Referrals to Broughton Hospital:</u> Since May 2006, CH has referred five patients to the Deaf Services Unit at Broughton Hospital.</p>	
Eliminate to a reasonable degree all suicide hazards in patient bedrooms and bathrooms (VIB1)	C	<p>CH Support Services has undertaken the task to correct as many CH hanging risks as manpower and budget will allow. For example, CH has removed cubicle curtain tracks from bathroom areas, as well as installed tamper-resistant screws in some of the air-conditioning access panels. Shower curtain rods are used that are of the less than 50lb. Break-away design. All glass lights have been replaced. CH is working on wardrobe closets to have the clothes rod replaced with the break-away design. Electrical switches and outlet plugs have been removed from patient bedrooms or have the tamper resistant feature. Where outlets are necessary, the metal conduit leading to them has been recessed, or the plugs are of the tamper resistant type, or else the electrical power has been removed until needed. CH has started in the U-2 bathrooms to replace the stall doors with a new design that will reduce the hanging risks, while at the same time provide adequate privacy. The ADA handrails in the toilet areas are also being replaced with a new design to help prevent</p>	<p>Commendable effort.</p> <p>Well done surveys by CH EOC Coordinator.</p>

		<p><i>hanging risks, as well as the toilet tissue holders. CH has replaced all the wire-spring beds with Barn Door type wooden beds. CH has also briefed all Environmental Services housekeepers to ensure that when trash is collected it is immediately taken to the dumpster. Trash cans have plastic liners for sanitary purposes; locks are installed on the lids in patient areas to prevent tampering. Maintenance work orders are routinely submitted to re-install hasps and locks when damaged or missing.</i></p> <p><i>Saw improved bathrooms U-1.</i></p> <p><i>Found safety and hanging risks pointed out to CH during tour.</i></p> <p><i>Note budgeted amounts and expenditures to date.</i></p> <p><i>Note plans for camera installations (equipment will be moved to new hospital).</i></p> <p><i>Note expected date of occupancy of new buildings is 2010.</i></p>	
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Staff Training

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Writing behavioral goals and objectives (IIIA3)	C		
Serving the needs of patients requiring specialized care (suicide risk (IIB4)), SIB, MI/MR, MI/SA (IIB2), Hearing impaired (IIB6)	C		
Risks and side effects in administering benzodiazepines	C	Benzodiazepine training occurred on April 17 and September 25, 2007.	
Risks and side effects in administering antipsychotic	C		

medication			
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Specific Documentation Requirements

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Behavioral goals and objectives which include, when possible, patient and family input (IIIA3)	PC	Behavioral Interventions have started out in the right direction. At this time, the process of developing behavioral plans is incomplete. Based on Behavioral Plans (BP) reviewed (see Data Base), no BP has an accompanying Behavioral Assessment (BA). I asked to see the BA's that accompanied the BP's and was told there are none. Training of nursing staff and documenting the training on patient-specific BP's is just as it should be.	Psychology Department needs to perform formal Behavioral Assessments and make these part of the Medical Record. The BA's need to include formally collected and reported data bases.
Treatment plans shall reflect an interdisciplinary process based upon reliable objective data and clearly established measurable goals (IIIA5a)	SC	See discussion above.	
Use of all medications (IIID1)	PC	See discussion above.	
Identify the symptoms and/or behavioral problem and tie to justification for the use of any antipsychotic medication or benzodiazepines (IIID4)	PC		Integration just beginning.
Clearly document behavioral issue(s) and tie to justification for use of intramuscular medication (IIID5a)	N/A	<i>NC statute allows IM administration of medication for oral refusal of medication without the requirement of the demonstration of behavioral requirements/emergency. Hence, a patient can receive an IM medication for a thought disorder absent any behavioral manifestation.</i>	
Use of restraints and seclusion documented and reviewed in a timely fashion by qualified staff (IVE)	C	<i>CH Quarterly QA Report.</i> <i>All documentation requirements for restrictive procedures were met in all cases reviewed: #0995423 (1/28 to 2/20/07), #1077814 (2/13/07), #1075991 (2/19/07), #0156558 (2/15/07),</i>	

		#1067179 (2/20/07).	
Criteria for release from restraints and seclusion clearly identified and written in patient's treatment plan (IVC)	N/A		<p>Not necessary on PCP.</p> <p>There is a section for patient to articulate preferences for controlling behavior.</p>
Provisions of nursing and medical care (VD)	SC	<p>Obesity addressed as a problem on the PCP: 1033363, 1075991, 0143774, 0172410, 1057792, 0975159, 0166756, 1008446, 0155937.</p> <p>Major improvements, but Physicians are still not writing progress notes with sufficient frequency to account for what they are doing and to inform others.</p>	<p>Attention to, and documentation of, obesity and its treatment is very good. This is extremely important in this population of seriously mentally ill individuals.</p> <p>Consider enforcement of and revision of CH Clinical Care Plan (policy and procedure), Progress Notes/Treatment Notes, Frequency and Content, effective 7-1-07 that impacts communication amongst staff. In terms of the psychiatrist, 1) When the patient requires acute level of care or has been in the hospital less than 60 days one time every 7 days; 2) When the patient requires non-acute level of care and has been in the hospital at least 60 days two times every 30 days; 3) When the patient requires PMU treatment due to a medical/physical need which cannot be managed in their home unit one time every 7 days.</p> <p>Patients on more than one antipsychotic medication shall have a Psychiatrist progress note addressing the rationale for the antipsychotic polypharmacy at least once a month. Patients on antipsychotic medications above the recommended total FDA dosage shall have a Psychiatrist progress note addressing the rationale for the dosage at least once per month.</p> <p>There are clinical triggers that shall necessitate a progress note by a Psychiatrist by the close of the next regular workday: 1) Medication changes (including one time orders, 2) STAT or NOW orders for medications, 3) Adverse drug reactions,</p>

			4) Use of seclusion and/or restraint (mandatory 1 hour assessment meets requirement), 5) Initiation of 1:1 observation, 6) Ordered change (initiation or discontinuation) in suicide precautions, 7) Significant changes in patient's symptoms, 8) Changes in diagnosis, 9) Transfers between CH units.
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Quality Assurance and Performance Improvement

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Detect timely and adequately problems with the provision of protections, treatment, services and supports and to ensure that appropriate corrective actions are implemented (VIA1)	C	<i>P/P: Incident/Accident Reports, VI-I-1 Sentinel Event/Near Miss, VI-S-5 CH Quarterly Report.</i>	
Actively collecting data relating to the quality of nursing and medical services (VIA1a)	C	<i>CH Quarterly QA Report.</i>	
Assessing data for trends (VIA1d)	C	<i>CH Quarterly QA Report.</i>	
Initiating inquiring regarding problematic trends and possible deficiencies (VIA1c)	SC	ADR's are not being adequately reported. Formerly, pharmacists participated in this process. Currently, physicians are only reports. There were only 8 ADR's reported for the 7 month period March-September 2007.	CH needs to revisit the process by which ADR's are reported. Serious unreporting is currently occurring. Overall, data collection is excellent, now need further translation to individual patient level.
Identifying corrective action (VIA1d)	SC	See section above.	See section above.
Monitoring to ensure appropriate remedies achieved (VIA1e)	SC	See section above.	See section above.
Conducting adequate mortality reviews to ascertain the root causes for all unexpected deaths (VIA4)	C	<i>Three deaths July 1, 2006-present. CH conducts a PI Department Death Chart Review, done by CH's Risk Manager. This then goes to Medical Staff Quality Improvement</i>	

		<p><i>Meeting. Unanticipated death results in root cause analysis (1/3 cases in this time period).</i></p> <p><i>See also NSPM: Suspicious Deaths, Sec VS-3.</i></p>	
System to oversee discharge process (VIIB3)	NC	<p>CH's end of the discharging process is problematic. A review of 15 Aftercare Plans for Community Follow-Up (see Data Base) showed that:</p> <ul style="list-style-type: none"> 5 patients left with MD appointments 6 patients left with an appointment with a staff with full name 3 patients left with an appointment with a staff with first name only 1 patient left with an appointment with unknown <p>Virtually no patient was discharged with any more than a list of desired services. Patients did not leave CH with specific services in place other than residence, or move case ACT (which was then the only contact the patient left with). Rep from LME is first meeting. The patient just a couple of days before discharge.</p> <p>This is considerably less than a state hospital should be doing when discharging its patients.</p>	

Communication

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Physician orders for enhanced supervision be communicated to appropriate staff (IIIB4b)	C	<i>Orders for level of observations clear; staff providing observation understood task when queried; observation check sheets appropriately completed.</i>	
Treatment team members communicate and collaborate effectively (IIID7)	SC	Based on observation of Treatment Teams, most were functioning well; one was an absolute disaster – see documentation from the patient whose PCP it was in Addendum	Major improvement.
Adequate and appropriate	SC	Based on observations of Treatment Teams and	Major improvement.

interdisciplinary communication among relevant professionals (VE,VI)		Group Leaders, communication from Team to Mall needs to continue to improve in the direction it is moving.	
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Staffing Requirements

<u>Item</u>	<u>Compliance</u>	<u>Findings</u>	<u>Comments and Recommendations</u>
Ensure a sufficient number of qualified staff to supervise suicidal patients (IIB4b)	C	<p><i>See NSPM 20-24.</i></p> <p><i>See P/P: Suicide, Suspected Risk, VI-S-2.</i></p> <p><i>When a patient is put on a 1:1 level of observation an additional staff person is added to the ward's staffing pattern to accommodate this. This is CH practice; not documented in policy.</i></p>	
Hire and deploy sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients with adequate supervision and medical and mental health treatment (VA)	PC	<p>Admissions: The number of admissions each fiscal year 2005, 2006, and 2007 is about 2 times what the number of admissions was in 1990. The average daily census in FY 2006 and FY 2007 is about 40% of what it was in 1990. Hence, CH cannot be staffed based on census alone. Admission rate needs to be a factor in determining staffing levels.</p> <p>Reason for Continued Stay are not specific and fail to justify further CH treatment</p> <p>0155937: "Mr. B. needs further stabilization and to develop social skills for community re-entry."</p> <p>0930073: Mr. P. "is actively delusional, but denies his mental illness."</p> <p>1083264: Mr. M. "presented to CH on affidavit and petition for involuntary commitment stating, 'Respondent is mentally ill and dangerous to self and others.'"</p> <p>Staffing is not sufficient when CH is over census.</p>	

		<p>U2 was over census 33% of the days between April 1, 2006 and September 3, 2007. The number over the staffed census of 90 ranged from 1 to 36 patients, 80 days, or 15% of the days, the U2 census was over by 10 or more patients. 25 days (4.5%) the U2 census was over by 20 or more patients.</p> <p>Per Policy, situations that may necessitate an increase in minimal staffing include but are not limited to:</p> <ul style="list-style-type: none"> a) Patients requiring 1:1 observation b) Several patients on a ward who have been placed on special precautions c) Opening an additional ward or going over capacity d) Sharp increase in episodes of seclusion and restraint e) Presence of patient(s) on ward who are extremely disruptive to milieu f) Activities requiring staff assistance/travel <p>This, however, affects only nursing staff.</p> <p>CH has several diversion contracts in place with private facilities that will be activated when necessary. CH has also begun diverting patients with substance abuse issues needing detoxification to Walter B. Jones. CH is collaborating with LMEs to ensure patients have crisis plans developed in the community. CH has not exercised its option to delay admissions when CH reaches 110% of capacity. CH anticipates having 30 long term patients transferred from DDH.</p> <p>There are 17 psychiatrists on staff, all but one of whom are full time. But of the 9 psychiatrists on the Admission Unit, 5 do their 40 hours across 4 days/week. They do this through cross coverage. This burdens some already overburdened psychiatrist caseloads ranged from 6 to 30 patients on the Admission Unit with psychiatrists receiving</p>	<p>CH is hurting with 5 vacant psychiatry positions. The 4-day workweek is a recruitment and retention requirement.</p>
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		between 2 and 10 admissions per week on the male side. In order to staff the Admission Unit, the Clinical Director must carry half a caseload. The psychiatrists on the Rehab Unit each carry over 25 patients.	
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If you should have any questions about this report, please feel free to contact me by telephone at 508-856-6527, by fax at 508-856-3270, or via email at jeffrey.geller@umassmed.edu.

Respectfully submitted,

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JG:vab